MDR Tracking Number: M5-04-1821-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 20, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit, therapeutic activities, man ther tech, hot/cold pack ther, and electrical stimulation were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 08-22-03 to 01-05-04 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24th day of May 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

May 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1821-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no

known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 36 year-old female who sustained a work related injury on ___. The patient reported that while at work a pallet fell on her injuring her back. The patient underwent x-rays of her back and was prescribed oral medications the same day. On 7/9/02 the patient sought treatment from a chiropractor and was begun on a course of physical therapy that included electrical stimulation, ultrasound, and chiropractic manipulation. The patient underwent a MRI of the lumbar spine on 10/21/02 that showed mild disc desiccation at L3-4, L5-S1, and a tiny annular fissure at L5-S1 with no disc protrusion or herniation. On 11/20/03 the patient underwent a lumbar discogram. The diagnoses for this patient have included lumbar muscle spasm and multiple disc desiccation of the lumbar spine. Treatment for this patient's condition has included neuromuscular reeducation, therapeutic procedures, cryotherapy, and injections.

Requested Services

Office visit, therapeutic activities, man ther tech, hot/cold pack ther, and electrical stimulation from 8/22/03 through 1/5/04.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 36 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar muscle spasm and multiple disc desiccation of the lumbar spine. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included neuromuscular reeducation, therapeutic procedures, cryotherapy, and injections. The ___ chiropractor reviewer explained that the patient did not demonstrate an improvement in her condition during treatment rendered 8/22/03 through 1/5/04. The ___ chiropractor reviewer also explained that treatment should have changed or stopped due to the lack of improvement in this patient's condition. Therefore, the ___ chiropractor consultant concluded that the office visit, therapeutic activities, man ther tech, hot/cold pack ther, and electrical stimulation from 8/22/03 through 1/5/04 were not medically necessary to treat this patient' s condition.

Sincerely,